

Case Number:	CM14-0111657		
Date Assigned:	09/16/2014	Date of Injury:	07/13/2000
Decision Date:	10/17/2014	UR Denial Date:	06/23/2014
Priority:	Standard	Application Received:	07/16/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and Pain Medicine and is licensed to practice in California and Washington. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 47-year-old female with a reported date of injury on 07/14/2000. The mechanism of injury was a fall. The diagnoses included cervical disc discopathy with radiculitis and bilateral carpal tunnel. The past treatments included pain medication and an intramuscular injection of Toradol. The MRI of the cervical spine performed on 03/17/2014 revealed no fractures or bone or soft tissue tumors, the intervertebral musculature is unremarkable, cervical lordosis is maintained below C4, and the alignment is maintained. There was no surgical history noted in the records. The subjective complaints on 02/07/2014 were constant neck pain that radiates to the upper extremities with numbness and tingling. The physical exam findings of the cervical spine noted tenderness at the cervical paravertebral muscle and upper trapezius muscle with spasms. There was also painful restricted cervical range of motion. The patient's medications consisted of cyclobenzaprine, Zofran, omeprazole, tramadol, and Terocin patches. The treatment plan was to continue and refill the medications. The request was received for omeprazole 20 mg quantity 120, ondansetron 8 mg ODT quantity 30, tramadol ER 150 mg quantity 90, and Terocin patch quantity 30. The rationale for the request was not provided. The Request for Authorization form was not provided in the records.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Omeprazole 20mg qty 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The request for Omeprazole 20mg qty 120 is not medically necessary. The California MTUS guidelines recommend omeprazole for patients taking NSAIDs who are shown to be at increased risk for gastrointestinal events or who have complaints of dyspepsia related to NSAID use. The notes do document that the injured worker is taking naproxen, however there is no documented evidence that she currently has dyspepsia related to NSAID use. In the absence of documented dyspepsia related to NSAID use the request is not supported by the guidelines. As such, the request is not medically necessary.

Ondasetron 8mg ODT qty 30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Ondansetron (Zofran®)

Decision rationale: The request for Ondansetron 8mg ODT qty 30 is not medically necessary. The Official Disability Guidelines state Zofran is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. The guidelines also state that Zofran is not recommended for nausea and vomiting secondary to chronic opioid use. The patient has chronic neck pain. There is no clear documented evidence in the notes that the injured worker had chemotherapy or radiation treatment. Additionally the rationale for the request was not provided. Furthermore, the request as submitted did not provide a frequency. In the absence of evidence that the injured worker underwent chemotherapy or radiation treatment the request is not supported by the evidence based guidelines.

Tramadol ER 150 mg qty 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The request for Tericlin patch qty 30 is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines also state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Tericlin patches contains

Lidocaine 2.50%, Capsaicin 0.025%, Menthol 10% and methyl salicylate 25%. In regard to lidocaine, the guidelines state that there are no commercially approved topical formulations of lidocaine for neuropathic pain other than Lidoderm brand patches. In regard to capsaicin, it is recommended only as an option in patients who have not responded or are intolerant to other treatments. In regard to Methyl salicylate is significantly better than placebo in chronic pain when used as mono therapy. There is no rationale provided why Methyl salicylate is to be compounded. For the reasons listed above the request is not supported by the guidelines. As such, the request is not medically necessary.

Tericin patch qty 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76.

Decision rationale: The request for Tramadol ER 150 mg qty 90 is not medically necessary. The California MTUS guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics first. The options that were tried and failed must be documented in the notes before a trial of opioid analgesics can be supported by the guidelines. Additionally there is no medication frequency noted in the request. In the absence of the above the request does not meet the evidence based criteria. As such the request is not medically necessary.